Exhibit "B"

Notice of Claim

eCLAIM Receipt

You have successfully filed your claim.

By successfully filing your claim, you have certified that all information provided is true and correct to the best of your knowledge and belief. You also understand that the willful making of any false statement of material fact herein may subject you to criminal penalties and civil liabilities.

Please allow up to 30 days to receive an email acknowledging your claim.

If you have any questions please contact 212-669-4729.

Your Receipt Number is the following:

[redacted]

You uploaded:
Claim Form: 1
Supporting Documents:0

7/19/2024 2:04 PM
Claimant Last Name:SALDARRIAGA
Claimant First Name:CHARLES

New York City Comptroller
Brad Lander

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Form Version: NYC-COMPT-BLA-PI1-E

Personal Injury Claim Form

Electronically filed claims must be filed within 90 days of the occurrence using the Office of the NYC Comptroller's website. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period to preserve your rights.

I am filing: ○ On behalf of myself.

○ On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:	
First Name:	
Relationship to the claimant:	

Claimant Information

*Last Name:	SALDARRIAGA
*First Name:	CHARLES
*Address:	1-20 ASTORIA BOULEVARD
Address 2:	APT 4H
*City:	ASTORIA
*State:	NEW YORK
*Zip Code:	11102
*Country:	USA
Date of Birth:	[redacted] *Format: MM/DD/YYYY*
Soc. Sec. #	
HICN: (Medicare #)	
Date of Death:	*Format: MM/DD/YYYY*
Phone:	
*Email Address:	
*Retype Email Address:	
Occupation:	

City Employee? ○ Yes ○ No ○ NA

Gender ○ Male ○ Female ○ Other

○ Attorney is filing.

Attorney Information (If claimant is represented by attorney)

+Firm or Last Name:	KOFMAN
+Firm or First Name:	LEBEDIN
+Address:	[redacted]
Address 2:	[redacted]
+City:	[redacted]
+State:	[redacted]
+Zip Code:	[redacted]
Tax ID:	
Phone #:	[redacted]
+Email Address:	[redacted]
+Retype Email Address:	[redacted]

The time and place where the claim arose

*Date of Incident:	07/16/2024 *Format: MM/DD/YYYY*
Time of Incident:	*Format: HH:MM AM/PM*
*Location of Incident:	QUEENS CRIMINAL COURT
Address:	125-01 QUEENS BOULEVARD
Address 2:	
City:	KEW GARDENS
*State:	NEW YORK
Borough:	QUEENS

Denotes required fields.
+Denotes field that is required if attorney is filing.
A Claimant OR an Attorney Email Address is required.

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***Manner in which claim arose:**

ON OR ABOUT MARCH 27, 2024, THE CLAIMANT WAS WRONGFULLY ARRESTED AND DETAINED BY RESPONDENTS, CITY OF NEW YORK, NEW YORK CITY POLICE DEPARTMENT, POLICE OFFICER WILLIAM PLANETA, AND JOHN DOES 1-10, PERSONS EMPLOYED BY THE CITY OF NEW YORK, WITHOUT PROBABLE CAUSE OR JUSTIFICATION. HE WAS IN CUSTODY FOR ABOUT ONE DAY.

RESPONDENTS WRONGFULLY CHARGED CLAIMANT WITH POSSESSION OF A FORGED INSTRUMENT FOR HIS LICENSE PLATE, EVEN THOUGH IT WAS VALID AND NOTHING WAS WRONG WITH IT, THEN COMMENCED A PROSECUTION AGAINST HIM WITHOUT PROBABLE CAUSE OR JUSTIFICATION. CLAIMANT HAD TO APPEAR IN COURT SEVERAL TIMES TO DEFEND HIMSELF AGAINST THE WRONGFUL CHARGES, HAS INCURRED ATTORNEY FEES AND LOST TIME FROM WORK, AND THE CAR SUSTAINED SEVERAL THOUSAND DOLLARS IN DAMAGES WHILE IN THE POSSESSION OF THE POLICE. ON JULY 16, 2024, THE QUEENS CRIMINAL COURT DISMISSED AND SEALED THE CHARGES AGAINST CLAIMANT.

THIS CLAIM IS FOR RESPONDENTS' VIOLATIONS AND DEPRIVATION OF CLAIMANT'S FUNDAMENTAL CONSTITUTIONAL AND STATUTORY RIGHTS UNDER THE UNITED STATES CONSTITUTION AND THE CONSTITUTION OF THE STATE OF NEW YORK, AS WELL AS THE LAWS OF THE STATE OF NEW YORK, THROUGH RESPONDENTS' ACTIONS AND/OR OMISSIONS, INCLUDING: INTENTIONAL AND/OR NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS, NEGLIGENT HIRING/TRAINING/SUPERVISION/RETENTION, NEGLIGENCE, AND GROSS NEGLIGENCE. THE FOREGOING HAS CAUSED CLAIMANT PERSONAL, PHYSICAL AND/OR MENTAL INJURIES AND DAMAGES, PAIN AND SUFFERING, EMOTIONAL TRAUMA, AND HUMILIATION AND FEAR.

RESPONDENTS CITY OF NEW YORK AND NEW YORK CITY POLICE DEPARTMENT ARE VICARIOUSLY LIABLE FOR THE ACTS OF THE AFORESAID AGENCIES, DEPARTMENTS, OFFICERS, AND INDIVIDUALS UNDER THE DOCTRINE OF RESPONDEAT SUPERIOR.

Denotes required field.

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The items of damage or injuries claimed are (include dollar amounts):

VIOLATION OF RIGHTS UNDER UNITED STATES CONSTITUTION $1,000,000
VIOLATION OF RIGHTS UNDER NEW YORK STATE CONSTITUTION $1,000,000
FALSE ARREST $1,000,000
ILLEGAL SEARCH $1,000,000
MALICIOUS PROSECUTION $1,000,000
INFLICTION OF EMOTIONAL DISTRESS/TRAUMA $1,000,000
PERSONAL INJURY $1,000,000
NEGLIGENT HIRING/TRAINING/RETENTION/SUPERVISION $1,000,000
NEGLIGENCE $1,000,000
LOSS OF REPUTATION $1,000,000

TOTAL AMOUNT CLAIMED: $10,000,000

PLEASE TAKE FURTHER NOTICE THAT BY REASON OF THE FOREGOING, CLAIMANT WAS DAMAGED IN THE SUM OF NO LESS THAN $10,000,000, PLUS INTEREST AND COSTS, OR ALTERNATIVELY, IN AN AMOUNT TO BE DETERMINED BY A COURT OR JURY AFTER TRIAL.

THE UNDERSIGNED THEREFORE PRESENTS THESE CLAIMS FOR ADJUSTMENT AND PAYMENT. YOU ARE HEREBY NOTIFIED THAT UNLESS IT IS ADJUSTED AND PAID WITHIN THE TIME PROVIDED BY LAW FROM THE DATE OF PRESENTATION TO YOU, THE CLAIMANT INTENDS TO COMMENCE AN ACTION ON THESE CLAIMS.

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Medical Information

1st Treatment Date:	*Format: MM/DD/YYYY*
Hospital/Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	
Date Treated in Emergency Room:	*Format: MM/DD/YYYY*

Was claimant taken to hospital by an ambulance? ◯ Yes ◯ No ◯ NA

Employment Information (If claiming lost wages)

Employer's Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	
Work Days Lost:	
Amount Earned Weekly:	

Treating Physician Information

Last Name:	
First Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	

Witness 1 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

Witness 2 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

Witness 3 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

Witness 4 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

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Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Non-City vehicle driver

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Insurance Information

Insurance Company Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	
Policy #:	
Phone #:	

Non-City vehicle information

Make, Model, Year of Vehicle:	
Plate #:	
VIN #:	

City vehicle information

Plate #:	
City Driver Last Name:	
City Driver First Name:	

Description of claimant:

◯ Driver ◯ Passenger
◯ Pedestrian ◯ Bicyclist
◯ Motorcyclist ◯ Other

Total Amount Claimed: $10,000,000.00 *Format: Do not include "$" or ",".*

*The **Total Amount Claimed** can only be entered once the following required fields are entered:*

Claimant Last Name
Claimant First Name
Claimant Address,City,State,Zip Code, and Country
Claimant Email or Attorney Email
Date of Incident
Location of Incident (including State)
Manner in which claim arose

If attorney is filing, the following fields are also required:
Attorney Last Name, First Name, Address, City, State, Zip Code, Email

I certify that all information contained in this notice is true and correct to the best of my knowledge and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties and civil liabilities.